Healthy Connections
South Carolina Department of Health and Human Services

Statement of Transfer of Assets

Answer the following questions as completely as possible as they apply to you, your spouse, and/or the person(s) for whom you are applying. You must complete, sign and return this form to Healthy Connections, or your eligibility may be affected. We may ask for additional information or documentation to establish your eligibility.

1. In the past five years have you sold or given away your home?

☐ No. If no, continue to Question 2. ☐ Yes. Fill in the following values, if known:

Appraised Value	Sale Price
$	$

2. In the past five years have you sold or given away other real estate?

☐ No. If no, continue to Question 3. ☐ Yes. Fill in the following values, if known:

Property	Appraised Value	Sale Price
	$	$
Property	Appraised Value	Sale Price
	$	$

Property	Appraised Value	Sale Price
	$	$
TOTAL	$	$

3. In the past five years have you sold or given away any motor vehicles?

☐ No. If no, continue to Question 4. ☐ Yes. Fill in the following values, if known:

Vehicle	Appraised Value	Sale Price
	$	$
Vehicle	Appraised Value	Sale Price
	$	$

Vehicle	Appraised Value	Sale Price
	$	$
TOTAL	$	$

4. In the past five years have you transferred or closed any type of bank, investment, retirement, or insurance account? Have you given away money or any other financial asset?

☐ No. ☐ Yes. Fill in the following values, if known:

Asset	Appraised Value	Sale Price
	$	$
Asset	Appraised Value	Sale Price
	$	$

Asset	Appraised Value	Sale Price
	$	$
TOTAL	$	$

Rights and Responsibilities

I have read the contents of this form, and the information contained herein is true, correct, and complete. If I become aware that any information in this form is not true, correct, or complete, I agree to notify Healthy Connections immediately. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this form may be punished by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicaid eligibility and the recovery of any payments made as a result of such omission, misrepresentation or falsification of information. I agree to provide proof of any information I have given, if requested. By my signature below I certify that I have read and agree to the rights and responsibilities stated on this page as well as those listed on the Healthy Connections application and attachments.

Signature:		**Date:**
Full Name (Print):	**Medicaid ID:**	**Phone:**